Policy:

FIN 001 Non-NHS Income

(Extension to Review Date ratified by ARC Jan 2021)

Executive or Associate Director lead	Executive Director of Finance
Policy author/ lead	Deputy Director of Finance
Feedback on implementation to	Deputy Director of Finance

Document type	Policy
Document status	Version 3.1
Date of initial draft	September 2017
Date of consultation	September 2017
Date of verification	December 2017
Date of ratification	21 December 2017
Ratified by	Executive Directors Group
Date of issue	22 December 2017
Date for review	**30/04/2021** *(Extended from December 2020)*

Target audience	Trust Staff, the Board of Directors and Council of Governors

Keywords	Non-NHS, income

Policy Version and advice on document history, availability and storage

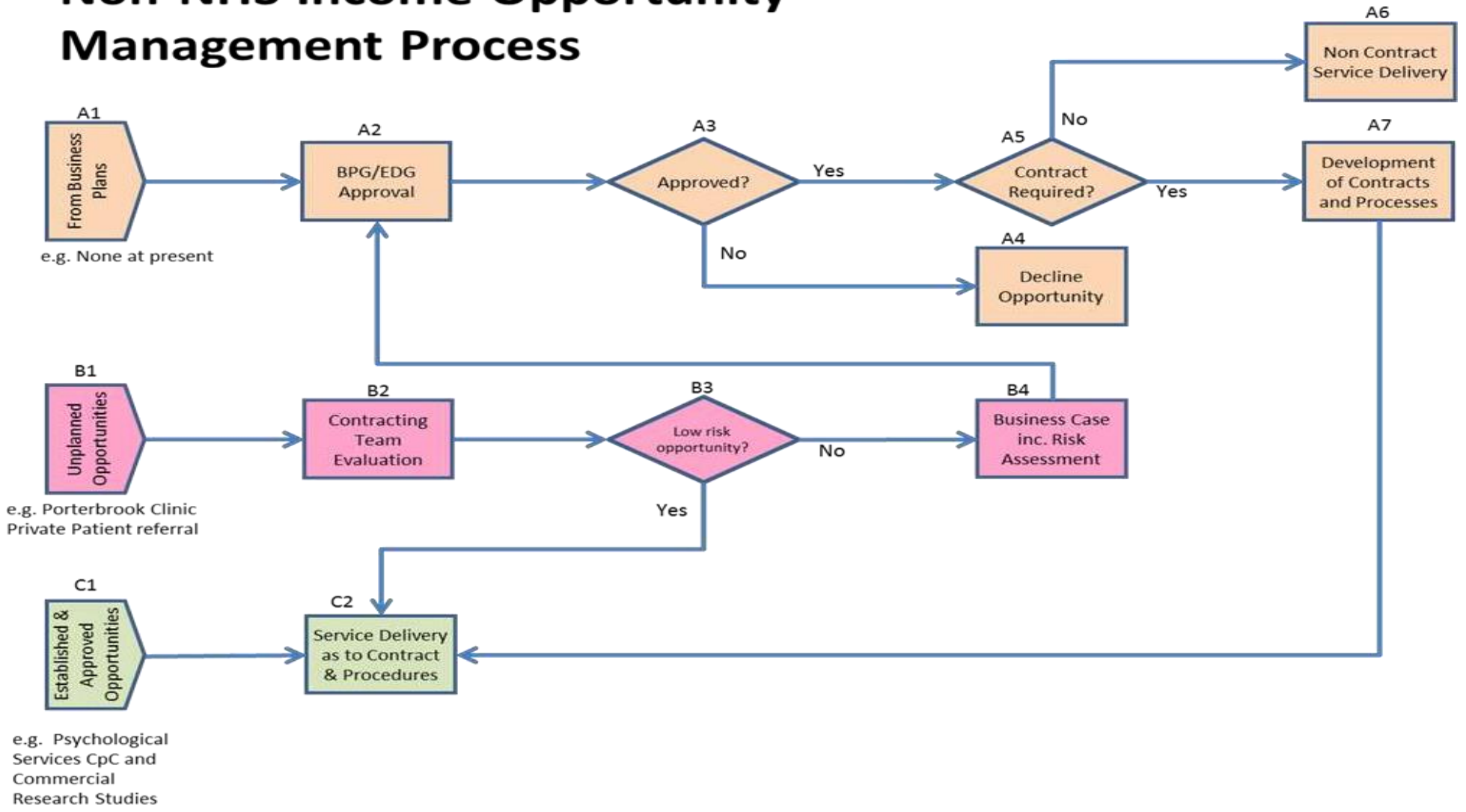
This is version 3.1 of this policy and replaces Version 3.0. The review date has been extended.

This is version 3.0 of this policy and replaces version 2 (November 2016). This version was reviewed and updated as part of an on-going policy document review process.

This policy will be available to all staff via the Sheffield Health & Social Care NHS Foundation Trust Intranet and on the Trust"s website. The previous version will be removed from the Intranet and Trust website and archived. Word and pdf copies of the current and the previous version of this policy are available via the Director of Corporate Governance.

Contents

Non-NHS Income Opportunity Management Process



1. Introduction

This policy sets out how the Trust reviews opportunities to secure Non NHS Income, and the approvals processes required to provide services from alternative funding sources.

2. Scope

2.1. This policy applies trust wide to all staff. It has particular relevance to those in the Trust who are involved in the evaluation of income opportunities such as Heads of Services, Service Directors and both the Contacting and Finance teams.

2.2. It includes the activities of SHSC clinician"s and their possible use of the trusts facilities, staff and services for the seeing of their own Private Patients. All requests for such use will be subject to this process.

2.3. It does not relate to income associated with overseas visitors as defined and addressed in the Department of Health publication Department of Health publication „Guidance on implementing the overseas visitor charging regulations" (updated August 2017).

2.4. This policy applies to all the Trust"s business including any wholly owned subsidiaries excepting where any such subsidiary has its own approved policy or its Memorandum of Understanding or similar document contains a relevant exemption.

2.5. For the avoidance of doubt, this policy **does not seek to exclude SHSC clinicians from carrying out their own private patient work** where they are compliant with their NHS contract, (specifically Schedule 9 of the Consultants Terms & Conditions, England 2003), other related SHSC policies and the DH Code of Practice for Private Practice.

2.6. This content of this policy is in accordance with the Trusts Terms of Authorisation from Monitor and the NHS Constitution.

3. Definitions

NHS Income:
Any income where the commissioner is NHS England, an NHS CCG or equivalent (this includes those comparable bodies, in Wales, Scotland and N Ireland), the NIHR, and public health /social care services commissioned by local authorities.

NIHR:
National Institute for Health Research, funded through the Department of Health to improve the health and wealth of the nation through research.

Non NHS Income:
Any income not falling under the definition of „NHS Income". This will include but not be limited to, commercially funded research, Private Patients, those „topping up" local authority funded provision and medico legal services.

Private Patients:
Those patients who give an undertaking (or for whom one is given) to pay charges for accommodation and services. This also includes parents of children who have

signing authority for their children.

4. Purpose

4.1. This policy is designed to ensure that as far as is reasonably possible, the following set of principles are upheld in consideration of the provision of services funded from Non NHS Income as defined above.

i. Non NHS Income clients, patients or organisations will not receive preferential treatment in ***any*** regard over NHS patients and in providing the services there shall be no clinical conflict with the delivery of NHS services. All patients, regardless of who pays, will be treated equally. (i.e. patients will be unable to obtain appointments within SHSC quicker than via normal referral processes, solely due to their ability to pay for their treatment).

ii. Where patients could/should receive the service via the NHS, we shall, where we are so aware, advise them of this.

iii. All charges will be based upon NHS costs/tariffs where they exist, with a margin applied to match the market rate, which in any event will normally be no less than 10%.

iv. Where no costed NHS service exists, the charge will be fully allocated and approved by the Finance Director or delegated representative(s) with reference to these principles.

v. Surplus income generated from Non NHS Income will be reinvested in the provision of NHS services; such investment may include building health related research capacity and capability.

vi. Services provided directly or through other parties should not give the opportunity for the good name of SHSC being brought into disrepute. For example, legal service providers that are associated with seeking unreasonable claims against employers, particularly NHS organisations, otherwise referred to as „ambulance chasers".

vii. When offering Non NHS Income services we will not normally compete with services offered by ourselves or other NHS providers that we partner with.

viii. Relevant summary statistics shall be gathered and reviewed on a regular basis and where considered appropriate, information gathered on patient demand for Non NHS Income services will be shared with our NHS commissioners as part of our strategy to maintain those positive relationships with regard to our NHS Income activities.

ix. Generally, those Non NHS Income services offered will be those which are not provided or commissioned locally by the NHS or Local Authority. A common exception would be where a patient pays for services otherwise funded by the Local Authority but through means testing has to self-fund or where they choose to top-up Local Authority funded services.

x. Pre payments will normally be required prior to commencement of a Non NHS Income service, unless agreed in advance with the Director of Finance.

xi. Providing Non NHS Income services will not in any way detract from the resources normally available for the delivery of NHS services, nor will they negatively impact on the quality of the NHS services. A risk assessment should be undertaken in each instance to ensure that NHS services will be maintained.

xii. Typically at business planning time, should the sum of any proposed increased income from non-NHS sources in any financial year represent 5% or more of our total income, (for example from 2% of income to 7%), prior approval of more than 50% of the voting council of governors must be obtained. If during the year subsequent opportunities suggest that the 5% approval figure required by the governors will be reached, the similar prior approval of the voting council of governors must be obtained before the acceptance of further opportunities that will breach the 5% increase limit. This is compliant with the Health and Social Care Act 2012 Section 164.

xiii. All Non NHS Income will be recorded with a financial identifier (tba) and will be administered with the same transparency as applies to NHS patient income.

xiv. A legally binding contract must be in place prior to commencement of the delivery of the service except where exceptional circumstances apply, when the prior approval of each of the Chairman, Chief Executive and Finance Director will be required.

xv. Requests from SHSC clinicians for use of SHSC facilities and resources in the treatment of their own Private Patients will normally be declined and the clinician encouraged to „refer" the client to SHSC in line with this policy.

xvi. The provision of any services overseas must have the prior approval of the board of directors.

5. Duties

The **Chief Executive** has overall responsibility for corporate governance and must ensure that systems are in place for effective policy governance.

Executive/Associate Directors are responsible for ensuring that the policy documents within their remits are maintained in accordance with this policy and for advising the Director of Corporate Governance or the relevant Clinical or Service Director with responsibility for a policy area. The Executive Director Group (EDG) are collectively responsible for ratifying Trust wide policies except for minor amendments. Individual Executive/Associate Directors have authority to ratify minor changes to Trust-wide / multi-Directorate policy documents and other policy documents; and to ratify local procedures, SOPs, protocols and guidelines.

The **Director of Corporate Governance** is responsible for managing and maintaining an effective policy governance system, ensuring that all policy documents are commissioned, developed and reviewed in accordance with this policy. They will ensure that policy documents are available through the Trust"s intranet and internet, kept up to date and reviewed as required and previous versions archived.

Clinical and Service Directors are responsible for nominating a designated policy lead who will liaise with the Director of Corporate Governance and identity and nominate appropriate policy authors for policies within their remit. They will also ensure that policy documents are developed and maintained in accordance with this policy and that their staff are aware of all policy documents and that their staff follow them.

Team managers are responsible for ensuring that all staff in their team are aware of this policy and adhere to this and all other policies and have access to where they are stored.

All staff have a responsibility to be aware of the Trust‟s policy documents and to understand that they must apply them. This includes staff who are seconded or work in Trust services through service level agreements and the Trust staff working in other Trusts or services. When staff are employed by one organisation and work within another, their contract or Service Level Agreement (SLA) must include their duties to abide by the policy documents of each organisation. If there is a conflict of policy documents between the two organisations, this must be addressed by the contract.

The Head of Equality and Inclusion will support and advise the Policy Lead / author regarding the Equality Impact Assessment Form and the Human Rights Act Assessment checklist.

Designated Policy Leads are responsible for authoring, or overseeing the authorship of their assigned policy documents; and project managing the development of new or revised documents, in liaison with other key stakeholders in line with the requirements of this policy.

Local governance groups and Trust-wide specialist governance groups are responsible for reviewing, making requests for additions or alterations and validating policy documents within their remit.

Joint Consultative Forum (JCF) includes staff side representatives, the Associate Director of HR and Deputy Director of HR, and promotes close co-operation between staff and managers within the Trust by providing a forum in which all matters affecting staff can be discussed and relevant information passed on. Decisions and outcomes on policies are recorded in the minutes of this meeting.

Virtual Policy Governance Group is a group set up to support the Director of Corporate Governance in order to maintain an effective policy governance system

6. Process

6.1. All opportunities to provide a service from Non NHS Income sources will be subject to this policy and follow the procedure detailed below and summarised in the Flowchart.

6.2. All Non NHS income opportunities would normally fall into one of the following three categories. Where an opportunity does not fit into any of these categories, or the opportunity would require a change to this policy, it will be considered as an „Unplanned Opportunity‟.

A. Business Planned Opportunity – any Non NHS Income project that has been identified through the business planning process
B. Unplanned Opportunities – any Non NHS Income project that is neither planned or approved
C. Established & Approved Opportunities – any Non NHS Income project that arises through existing procedures set up for the purposes of managing and processing the opportunity

6.3. The different opportunities will follow the paths as set out in the Flowchart Appendix H - and as detailed below:

A - Business Planned Opportunity

A1 Business planned opportunities will normally be identified through the business planning round but can also include any other opportunities that are developed requiring business planning approval.

A2 Whether originating through business planning or unplanned paths, opportunities will initially be considered by the Business Planning Group (BPG) who will decide whether or not to recommend approval to the Executive Directors Group (EDG).
In the event that commercial timeliness requires a quick decision and the full BPG is not available, approval will be gained via the EDG direct.

A3 The approval process, including EDG approval where required, will decide whether or not the opportunity is progressed or declined.

A4 Where declined the decision and its rationale will be confirmed to the originating service / clinical director.

A5 The approval process will further require that should any opportunity progress for whatever reason without any acceptable form of contract, prior approval of both the Chief Executive and Finance Director will be necessary.

A6 In the event of non-contracted service delivery, this will be carried out with due regard to the associated risks and the principles of this policy as set out under clause 4.1.

A7 Contracts for approved opportunities will be developed by the Contracts Team in conjunction with the relevant service(s). Contracts and processes to allow delivery of the service will be compliant with the principles of this policy as set out under clause 4.1 and other relevant SHSC policies and procedures.

The contractual development will be in accordance with normal contracting procedures, which includes an assessment of insurance cover appropriate to the service and legal advice being sought where appropriate.

Detailed procedures will be to a level of detail appropriate to the service requirements. Examples are to be found within those used for processing Non NHS Income (Cost per Case) for psychological services (see Appendix G) and the Research Development Unit‟s contracting processes.

B - Unplanned Opportunities

B1 Unplanned opportunities would include where an approach is made to a service by a private individual or organisation, or where a project is identified through the gathering of market intelligence such as may be obtained by employees carrying out their normal duties.

B2 All such opportunities will be forwarded to the Deputy Director of Finance who will lead an evaluation of the opportunity. Such evaluation will be undertaken together with the appropriate Service/Clinical Director, using the guidance set out in Appendix H – Opportunity Evaluation Guidance.

B3 If initial evaluation of the opportunity indicates low risk, approval will be provided as long as the opportunity is in accordance with this policy.

B4 In the event the opportunity is considered to be other than low risk, a business case, as required by the BPG but in any event containing a risk assessment, shall be prepared by the relevant service lead .This will be considered in line with clause A2.

C – Established & Approved Opportunities

C1 Such opportunities would typically be where a commercial research contract opportunity is identified and uses the well-established and proven research governance and contracting processes which include industry standard contracts. Similarly, where a case management company approaches an SHSC consultant for their services and the consultant refers them on to the Psychological Services team.

C2 In these instances, the service is delivered in accordance with detailed procedures, costing templates and contracts. An extract from the procedures in use within Psychological Services processes are included as Appendix G.

7. Dissemination, storage and archiving (Control)

This is the second issue of such a policy and therefore it supersedes version 1 of this policy. In the first instance the Heads of Service, Finance and Contracts Team and associated corporate teams will be specifically made aware of the issue of this new policy and the requirement to read, understand and comply with it. At the same time the policy will be made available on the SHSC intranet and available to all staff. An email will be sent to “All SHSC” staff informing them in the event of a policy revision.

The Corporate Governance Directorate is responsible for ensuring current versions are available on the intranet for future reviews of the policy.

8. Training and other resource implications

The contracting arrangements for Non NHS Income will require the use of terms and conditions that reflect the differing parties and their associated risks. This will vary from contracting with individual members of the public to large and possibly international organisations. Where they do not exist, creation of such standard

terms and conditions for these differing circumstances may require some additional resources including legal advice.

Where detailed procedures are developed in support of a specific Non NHS Income stream, such as exist for the processing of individual medico legal cases, see Appendix G, there will be a need for training and awareness sessions to ensure that those involved in the process are familiar with what is required of them.

9. Audit, monitoring and review

The Audit Committee will ensure arrangements are established to test compliance of actual working practices with the provisions of this policy in order to identify areas requiring attention.

The Policy will be reviewed every three years or sooner if any major changes occur in legislation, a significant change in the services SHSC provide (such as if we commenced the offering of Private Patient beds), guidance or policies which have an impact on the provisions of this policy.

Monitoring Compliance Template						
Minimum Requirement	Process for Monitoring	Responsible Individual/ group/ committee	Frequency of Monitoring	Review of Results process (e.g. who does this?)	Responsible Individual/group/ committee for action plan development	Responsible Individual/group/ committee for action plan monitoring and implementation
A) Application of policy	Review and through Audit and contract reviews of contracts prior to approval/signature	Finance	Annual	Quality Assurance Committee	Education & Training Steering Group	Quality Assurance Committee

10.

Action / Task	Responsible Person	Deadline	Progress update
New policy to be uploaded onto the Intranet and Trust website.	Head of Communications	Within 5 working days of ratification.	
A communication will be issued to all staff via the Communication Digest immediately following publication.	Head of Communications	Within 5 working days of issue.	
A communication will be sent to Education, Training and Development to review training provision.	Finance Department	Within 5 working days of issue.	
Specifically make the Heads of Services, Service Directors and both the Corporate and Finance teams aware of the policy and their roles within it.	Deputy Director of Finance	Within one month of ratification.	

1 Links to other policies, standards and legislation (associated documents)

CG 001 Managing Conflicts of Interest in the NHS Policy (9 Nov 2017)

Standing Orders, Reservation & Delegation of Powers, incorporated the Scheme of Delegation & Standing Financial Instructions Policy (September 2016)

DH Code of Practice for Private Practice

Health and Social Care Act 2012 (Section 164)

Accessing Legal Advice Policy (April 2014)

Terms and Conditions – Consultants (England) 2003 Version 9 - 31 March 2013

SHSC Constitution (August 2016)

SHSC Monitor Terms of Authorisation (inc Addendum effective 1 October 2012)

Monitor SHSC Provider Licence Issued 1 April 2013

2 Contact details

The following are the names, job titles and contact details for the staff who should be contacted for guidance in using this policy.

Title	Name	Phone	Email
Deputy Director of Finance	James Sabin	0114 2263384	james.sabin@shsc.nhs.uk
Head of Contracts & Tender Management	Dani Hydes	0114 271 6723	dani.hydes@shsc.nhs.uk

13 References

DH: publication „Guidance on implementing the overseas visitor charging regulations" (updated August 2017).

FTN document: Non-NHS income; renaming of the governor body; accounts: initial arrangements; Advice on implementation of the new provisions of the Health and Social Care Act 2012.

Health and Social Care Act 2012 (Section 164)

DH Code of Practice for Private Practice

Monitor publication: Your duties: a brief guide for NHS foundation trust governors (March 2014)

Appendix A – Version Control and Amendment Log

Version No.	Type of Change	Date	Description of change(s)
1	Draft policy creation	Sept 2014	Initial version.
	Drafting Update (KL)	1st Oct 14	Wording changes
	Drafting Update (KL)	3 Nov 2014	Amendments, additions and deletions
	Drafting Updates	11 Nov and 17th 2014	Additions to clause 10 and minor wording updates.
	Final changes following Council of Governors review	23 Dec 2014	Addition of Chairman to clause 4.1 xiv
V2 D0.1	Review on expiry	Sept 2016	Draft changes produced
V2	Ratification / finalisation / issue	November 2016	
V3 D0.1	Review	October 2017	Draft changes produced
V3	Ratification / finalisation / issue	December 2017	
V3.1	Extension to review date	November 2020	Review date extended to 30/04/2020 by PGG/Finance and Performance Committee

Appendix B – Dissemination Record

Version	Date on website (intranet and internet)	Date of "all SHSC staff" email	Any other promotion/ dissemination (include dates)
1.0	Dec 2014	Dec 2014	
2.0	Nov 2016	Nov 2016 via Communications Digest	
3.0	TBA	TBA	

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Appendix C – Stage One Equality Impact Assessment Form

Equality Impact Assessment Process for Policies Developed Under the Policy on Policies

Stage 1 – Complete draft policy

Stage 2 – **Relevance** - Is the policy potentially relevant to equality i.e. will this policy potentially impact on staff, patients or the public? If **NO** – No further action required – please sign and date the following statement. If **YES –** proceed to stage 3

No, Dani Hydes, Head of Contracts and Tender Management

This policy does not impact on staff, patients or the public (insert name and date)

Stage 3 – **Policy Screening** - Public authorities are legally required to have „due regard" to eliminating discrimination, advancing equal opportunity and fostering good relations, in relation to people who share certain „protected characteristics" and those that do not. The following table should be used to consider this and inform changes to the policy (indicate yes/no/ don"t know and note reasons). Please see the SHSC Guidance on equality impact assessment for examples and detailed advice. This is available by logging-on to the Intranet first and then following this link https://nww.xct.nhs.uk/widget.php?wdg=wdg_general_info&page=464

	Does any aspect of this policy actually or potentially discriminate against this group?	**Can equality of opportunity for this group be improved through this policy or changes to this policy?**	**Can this policy be amended so that it works to enhance relations between people in this group and people not in this group?**
AGE			
DISABILITY			
GENDER REASSIGNMENT			
PREGNANCY AND MATERNITY			
RACE			
RELIGION OR BELIEF			
SEX			
SEXUAL ORIENTATION			

Stage 4 – **Policy Revision** - Make amendments to the policy or identify any remedial action required (action should be noted in the policy implementation plan section)

Please delete as appropriate: Policy Amended / Action Identified / no changes made.

Impact Assessment Completed by (insert name and date)

Appendix D - Human Rights Act Assessment Form and Flowchart

You need to be confident that no aspect of this policy breaches a person"s Human Rights. You can assume that if a policy is directly based on a law or national policy it will not therefore breach Human Rights.

If the policy or any procedures in the policy, are based on a local decision which impact on individuals, then you will need to make sure their human rights are not breached. To do this, you will need to refer to the more detailed guidance that is available on the SHSC web site http://www.sct.nhs.uk/humanrights-273.asp (relevant sections numbers are referenced in grey boxes on diagram) and work through the flow chart on the next page.

1. Is your policy based on and in line with the current law (including caselaw) or policy?

☑ **Yes. No further action needed.**

☐ **No. Work through the flow diagram over the page and then answer questions 2 and 3 below.**

2. On completion of flow diagram – is further action needed?

☐ **No, no further action needed.**

☐ **Yes, go to question 3**

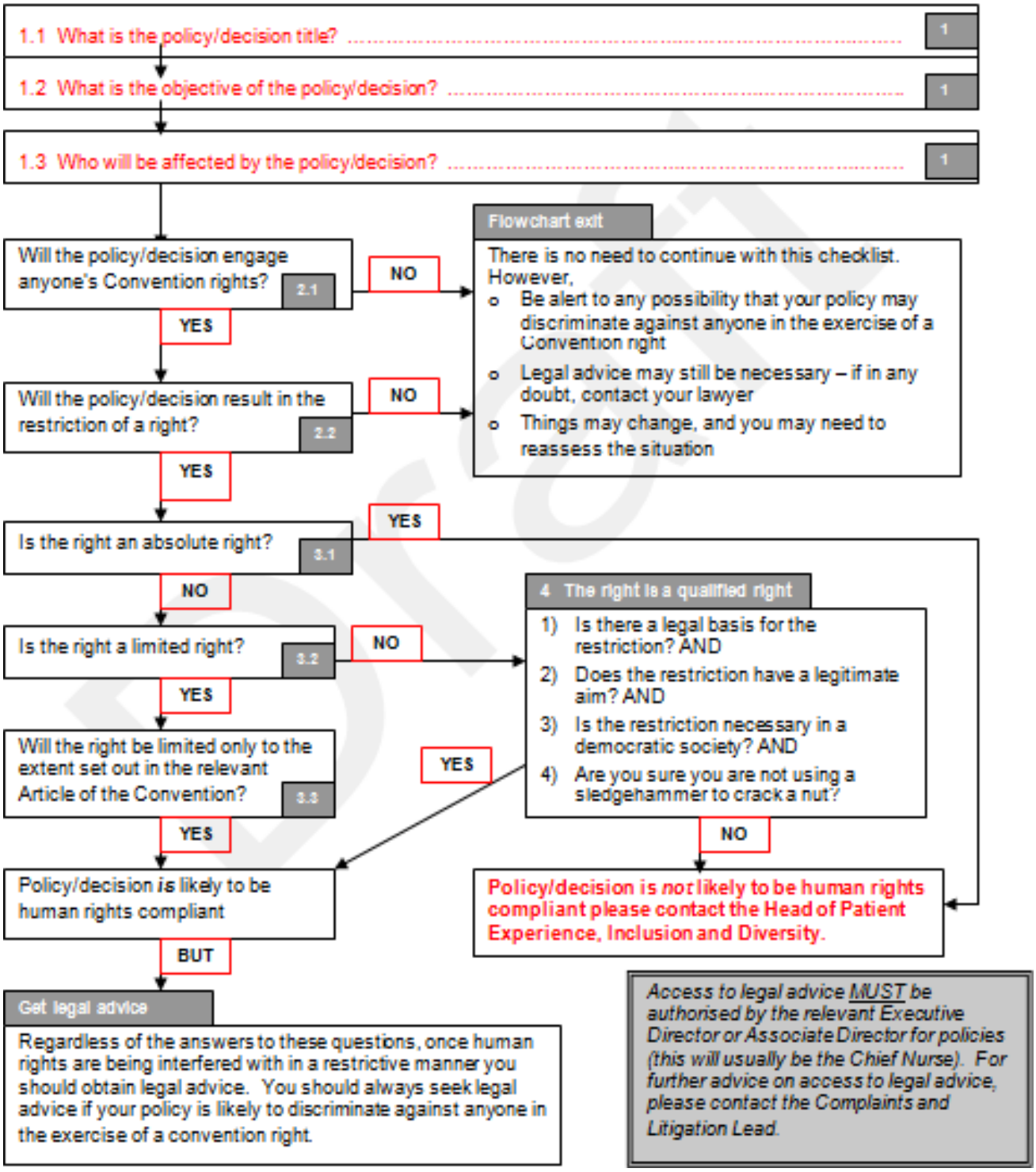
3. Complete the table below to provide details of the actions required

Action required	By what date	Responsible Person

Human Rights Assessment Flow Chart

Complete text answers in boxes 1.1 – 1.3 and highlight your path through the flowchart by filling the YES/NO boxes red (do this by clicking on the YES/NO text boxes and then from the Format menu on the toolbar, choose 'Format Text Box' and choose red from the Fill colour option).

Once the flowchart is completed, return to the previous page to complete the Human Rights Act Assessment Form.



Appendix E - Development and consultation process

Version 1 input taken from:

Rosie McHugh, Director of Organisation Development/Board Secretary, (reference to the 2014 McIvor report)

PPI papers, contracts and procedures developed with Gwyneth De Lacy, Director of Psychological Services

Nicholas Bell, Research Director

Nigel Donaldson, Deputy Director of Human Resources

Tim Peacock, Commercial Advisor (external/interim)

Paul Robinson, Finance Director

James Sabin, Principal Accountant

Ken Lawrie, Director of Commercial Relations

Business Planning Group

Executive Directors Group

Board of Directors

Documents as listed in Clause 13

Version 2 September 2016 Revision input taken from:

Tim Peacock, Commercial Advisor (external/interim)

Lynsey Neath, Commercial advisor (external/interim)

Dani Hydes, Head of Contracts and Tender Management

This policy was verified by the Business Planning Group in October 2016 prior to being submitted to the Executive Directors Group for ratification.

Version 3 October 2017 Revision input taken from:

Tim Peacock, Commercial Advisor (external/interim)

Dani Hydes, Head of Contracts and Tender Management

Appendix F –Policies Checklist

Please use this as a checklist for policy completion. The style and format of policies should follow the Policy Document Template which can be downloaded on the intranet.

1. Cover sheet	✓
All policies must have a cover sheet which includes:	
• The Trust name and logo	
• The title of the policy (in large font size as detailed in the template)	✓
• Executive or Associate Director lead for the policy	✓
• The policy author and lead	✓
• The implementation lead (to receive feedback on the implementation)	✓
• Date of initial draft policy	✓
• Date of consultation	✓
• Date of verification	
• Date of ratification	
• Date of issue	
• Ratifying body	
• Date for review	✓
• Target audience	✓
• Document type	✓
• Document status	✓
• Keywords	✓
• Policy version and advice on availability and storage	✓
2. Contents page	✓
3. Flowchart	✓
4. Introduction	✓
5. Scope	✓
6. Definitions	✓
7. Purpose	✓
8. Duties	✓
9. Process	✓
10. Dissemination, storage and archiving (control)	✓
11. Training and other resource implications	✓

12. Audit, monitoring and review ✓

This section should describe how the implementation and impact of the policy will be monitored and audited and when it will be reviewed. It should include timescales and frequency of audits. It must include the monitoring template as shown in the policy template (example below).

Monitoring Compliance Template

Minimum Require-ment	Process for Monitoring	Responsible Individual/ group/ committee	Frequency of Monitoring	Review of Results process (e.g. who does this?)	Responsible Individual/group/ committee for action plan development	Responsible Individual/group/ committee for action plan monitoring and implementation
A) Describe which aspect this is monitoring?	e.g. Review, audit	e.g. Education & Training Steering Group	e.g. Annual	e.g. Quality Assurance Committee	e.g. Education & Training Steering Group	e.g. Quality Assurance Committee

✓

13. Implementation plan

14. Links to other policies (associated documents) ✓

15. Contact details ✓

16. References ✓

17. Version control and amendment log (Appendix A) ✓

18. Dissemination Record (Appendix B) ✓

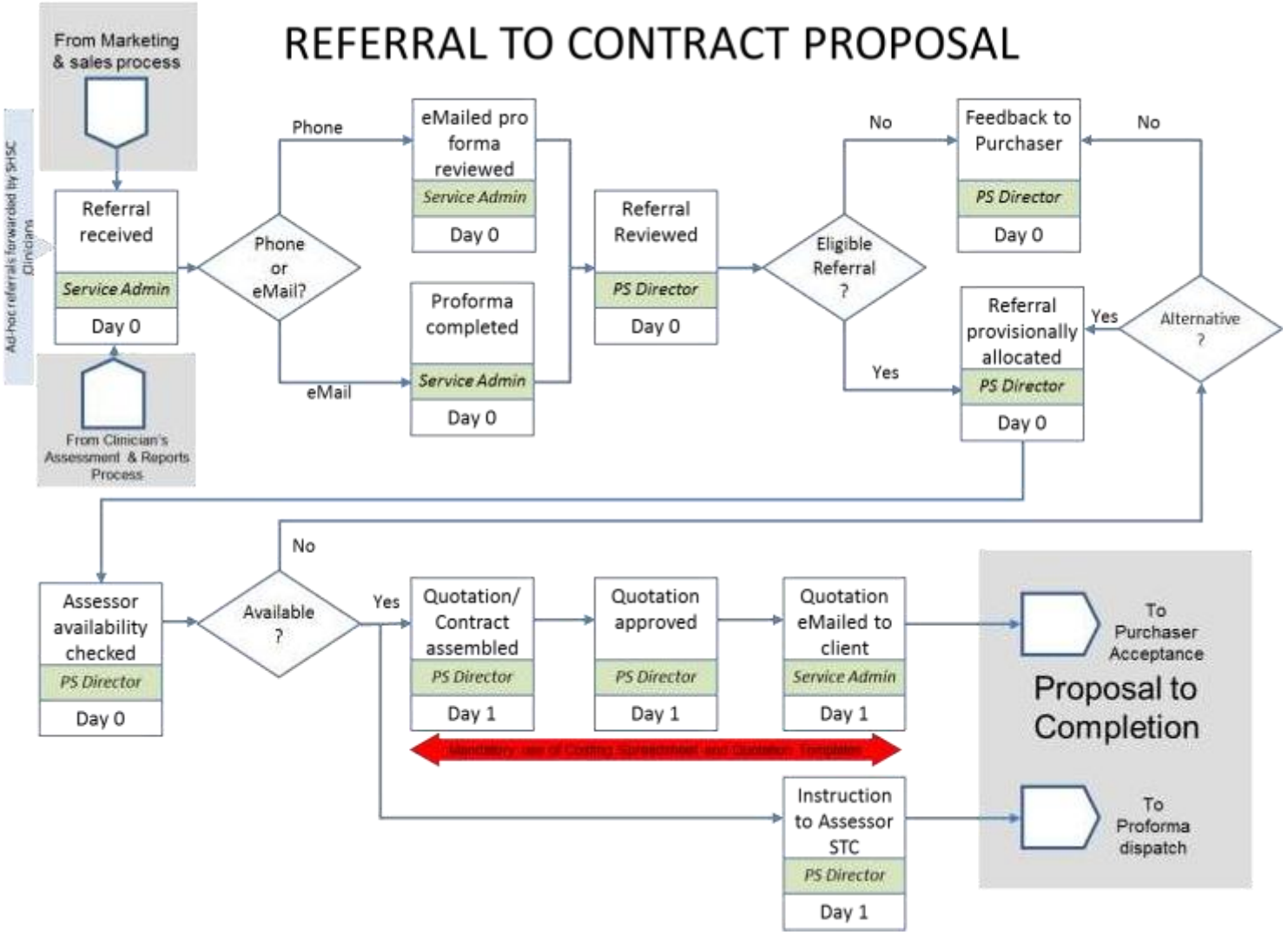
19. Equality Impact Assessment Form (Appendix C) ✓

20. Human Rights Act Assessment Checklist (Appendix D) ✓

21. Policy development and consultation process (Appendix E) ✓

22. Policy Checklist (Appendix F) ✓

Appendix G – example of Non NHS Income stream procedures (Psychological Services Medico Legal & Cost per Case)



NOTE: This is an extract from a set of detailed procedures held by Contracts Team and Psychological Services.

Similarly robustly documented procedures exist for research contracts that include commercially sponsored trials. These are held by the Contracts Team and the Research Development Unit.

Does not normally require further approval when any of the below are a feature of the opportunity, and *non* of the adjacent are present:	**Will require Business Case and EDG/BPG approval when any of the below are a feature of the opportunity:**
The value is under £4,999 The service to be provided is that which already has documented and agreed procedures and contracts. The service to be provided is very similar to those for which documented and procedures and contracts already exist requiring little or no changes.	When any of the principles under clause 4.1 cannot be met. The estimated value is above £5,000 The service is to be provided outside of the United Kingdom, where approval of the Board of Directors will also be required.